Assistive Technology British Columbia
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Declaration of Disability

Form B: For Learning Disorders, ADD/ADHD, and Mental Health Disorders

Not to be used for: Sensory Impairments or Other Medical Conditions (use Form A instead)

Instructions for the Applicant:

- Complete and sign **Section I only**. Do **not** modify any other section of this form.
- Have all sections relating to your disorder(s) completed by the appropriate eligible assessor (**Note**: only one assessor may fill out the form. If you submit information from multiple assessors, you must submit a separate form from each assessor.)
- If you have a specific Learning Disorder you must **attach a recent Psycho-Educational assessment**, completed by a Registered Psychologist within the last 5 years.
- By completing this form, you **consent** to allowing ATBC to **gather and process the information** requested for the purposes stated on this form, and to **contact your medical assessor** if additional information is required.

Instructions for the Assessor:

Important: Not all medical conditions are considered permanent disabilities for the purpose of this program. The purpose of this form is to gather information to determine the Applicant's eligibility for publicly funded programs and to plan appropriate accommodations based on the Applicant's functional impairments.

You must confirm that you have expertise in the diagnosis of the documented mental disorder(s) or condition(s) in adolescents and adults and your diagnostic methodology must follow established practices in the field.

Note: A separate report that includes all of the necessary information outlined below may also be acceptable in place of this verification form.

- For specific Learning Disorders, please complete Section II *and attach a recent Psycho-Educational assessment*
- For Attention Deficit/Hyperactivity Disorder, please complete Section III
- For Mental Health Disorders, please complete Section IV

  All Assessors must complete Section V.

If you have any questions or require guidance on completing this form, please contact Assistive Technology BC at (604) 264-8295.

Section I: Personal Information (To be completed by the Applicant)		
Legal Last Name:		Date of Birth (MM/DD/YYYY):
Legal First Name:	Middle Initial:	Telephone Number:
Address:		Email:
City/Town:	Province:	Postal Code:
Signature (in ink):		Date:

Section II: Learning Disorders
(To be completed by a Registered Psychologist or Certified School Psychologist)

Applicants requesting accommodation for a Learning Disorder **must** submit a Psycho-Educational assessment that has been completed within the past five years[1]. The checklist below is a guide to the basic *minimum* eligibility requirements for Learning Disorder documentation.

Note: This checklist is a guide only and does not guarantee the eligibility of the documentation.

Qualifications of Assessor

I certify that I am (choose only one):

☐ A **Registered Psychologist** with expertise in diagnosing learning disorders

or

☐ A **Certified School Psychologist** and a member in good standing with the B.C. Association of School Psychologists at the time of the assessment*

*__Note__: You must be or have been employed by a provincially funded school board/college/university at the time of the learning disability assessment. B.C. certified school psychologists conducting learning disability assessments outside their employment role (e.g. private consultation) are not considered "eligible" assessors.

or

☐ A Registered Psychologist or Registered Psychological Associate **with limited register designation** and expertise in diagnosing learning disorders†

†**Note**: Psychologists or Psychological Associates practicing with a Limited Register designation **must** submit a copy of the letter from the College of Psychologists of B.C. describing the restrictions to their practice.

Documentation

The attached Psycho-Educational assessment report:	
☐	Describes a **comprehensive** psychoeducational assessment that was completed within the past **five** years[1]
☐	Is **signed** and includes full **contact details** for the assessor on **formal letterhead**
☐	Describes academic deficit that presents in the **classroom** and in **standardized tests**
☐	Describes academic deficit that has **emerged and persisted** despite "adequate schooling"
The Psycho-Educational report contains the following **methodological features**:	
☐	Use of appropriate **norm-referenced** assessment instruments
☐	Appropriate **reporting** of test results and student history
☐	A clearly stated **DSM-IV diagnosis**
☐	Test results that **support the DSM-IV diagnosis** of a Learning Disorder **and**
☐	A **clear explanation**, with reference to the relevant portions of the DSM-IV and the current assessment, describing why the Learning Disorder diagnosis is appropriate in this case

[1] For students in transition to post-secondary education, a more current assessment may be required.

Section III: Attention Deficit/Hyperactivity Disorders
(To be completed by a Registered Psychologist, Psychiatrist, or Physician with specialized training)

1. **Please check one:** I certify that I am a ☐ **Registered Psychologist**, ☐ **Psychiatrist**, or a ☐ **Physician** with expertise in diagnosing and/or treating Attention Deficit/Hyperactivity Disorder.

2. Indicate your **DSM-IV diagnosis** for the Applicant:

DSM-IV Diagnosis	DSM-IV Diagnostic Code	Date of Diagnosis

3. In addition to the DSM-IV criteria, I certify that I used the following **diagnostic measures** to arrive at the diagnosis (please check all relevant items below):

☑	Diagnostic Measures Used (check all that apply)		
☐	Structured/unstructured interviews with patient	☐	Developmental history
☐	Interviews with other persons	☐	Educational history
☐	Behavioural observations	☐	Medical history
☐	Neuropsychological testing (please enclose report if completed within last 5 years)		
☐	Standardized or non-standardized rating scales (please specify): →		
☐	Other (please specify): →		
☐	**I did not diagnose the Applicant**. S/he was diagnosed by Dr. _____ on (date) _____. (**Please enclose report from original assessor/diagnostician.**)		

4. Indicate on each scale the number that best represents the Applicant's **current level of functioning**, *even with treatment*, for the activities of daily living listed below.

School/Work/Life Activity	No Limitation → Totally Impaired	Unknown/Not Assessed ☑
Following simple instructions	1----------2----------3----------4----------5	☐
Following complex instructions	1----------2----------3----------4----------5	☐
Reading a scholarly article	1----------2----------3----------4----------5	☐
Reading a newspaper article	1----------2----------3----------4----------5	☐
Taking notes in class	1----------2----------3----------4----------5	☐
Managing internal distractions	1----------2----------3----------4----------5	☐
Managing external distractions	1----------2----------3----------4----------5	☐
Completing tasks on time	1----------2----------3----------4----------5	☐
Making/keeping appointments	1----------2----------3----------4----------5	☐
Organizing	1----------2----------3----------4----------5	☐
Other: _____	1----------2----------3----------4----------5	

5. List the major symptoms of the disorder that **currently affect the Applicant**, *even with treatment* (be sure to **include any significant side effects** from medication that affect the Applicant; attach an additional sheet if required):

Symptom	Persists with Medication ☑
	☐
	☐
	☐
	☐

Section IV: Mental Health Disorder (To be completed by a Registered Psychologist, Psychiatrist, or Physician)

1. **Please check one:** I certify that I am a ☐ **Registered Psychologist**, ☐ **Psychiatrist**, or a ☐ **Physician** with expertise in diagnosing and/or treating the condition(s) indicated below.

2. Indicate your **DSM-IV diagnosis** for the Applicant:

DSM-IV Diagnosis	DSM-IV Diagnostic Code	Date of Onset	Expected to Persist ☑
			☐ Less than 2 years ☐ 2+ years ☐ Not expected to improve
			☐ Less than 2 years ☐ 2+ years ☐ Not expected to improve
			☐ Less than 2 years ☐ 2+ years ☐ Not expected to improve

3. In addition to the DSM-IV criteria, I certify that I used the following **diagnostic measures** to arrive at the diagnosis (please check all relevant items below):

☑	Diagnostic Measures Used (check all that apply)		
☐	Structured/unstructured interviews with patient	☐	Developmental history
☐	Interviews with other persons	☐	Educational history
☐	Behavioural observations	☐	Medical history
☐	Neuropsychological testing (**enclose report** if completed within last 5 years)		
☐	Standardized or non-standardized rating scales (please specify): →		
☐	Other (please specify): →		
☐	**I did not diagnose the Applicant**. S/he was diagnosed by Dr. _____ on (date) _____. (**Please enclose report from original assessor/diagnostician.**)		

4. List the major symptoms of the disorder that **currently affect the Applicant**, *even with treatment* (be sure to **include any significant side effects** from medication that affect the Applicant; attach an additional sheet if required):

Symptom	Persists with Medication ☑	Frequency			
		Daily	Weekly	Monthly	Other (Specify)
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

5. Indicate on each scale below the number that best represents the Applicant's **current level of functioning**, *even with treatment*, for the activities of daily living listed below.

School/Work/Life Activity	No Limitation ⟶ Totally Impaired	Unknown/Not Assessed ☑
Staying on task	1----------2----------3----------4----------5	☐
Following simple instructions	1----------2----------3----------4----------5	☐
Following complex instructions	1----------2----------3----------4----------5	☐
Reading a scholarly article	1----------2----------3----------4----------5	☐
Reading a newspaper article	1----------2----------3----------4----------5	☐
Taking notes in class	1----------2----------3----------4----------5	☐
Living alone	1----------2----------3----------4----------5	☐
Sleeping	1----------2----------3----------4----------5	☐
Eating	1----------2----------3----------4----------5	☐
Interacting socially	1----------2----------3----------4----------5	☐
Managing self care	1----------2----------3----------4----------5	☐
Managing internal distractions	1----------2----------3----------4----------5	☐
Managing external distractions	1----------2----------3----------4----------5	☐
Completing tasks on time	1----------2----------3----------4----------5	☐
Attending classes regularly	1----------2----------3----------4----------5	☐
Making/keeping appointments	1----------2----------3----------4----------5	☐
Managing stress	1----------2----------3----------4----------5	☐
Organizing	1----------2----------3----------4----------5	☐
Other: _____	1----------2----------3----------4----------5	

Section V: Additional Information (To be completed by all Assessors)

1. Indicate the following:

   a. Date the Applicant was first seen by you: _____

   b. How frequently you have treated the Applicant **in the past 2 years**[2] (choose only one):

   ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other: _____

2. Is there **anything else** you think we should know about the Applicant's disorder (including recommendations for support)?

Certifying Medical Professional

*I certify that the information provided on this form is **accurate and current** to my knowledge and that the person identified in this assessment as "the Applicant" **experiences the impairments** I have indicated.*

Name of Certifying Medical Assessor:		Registration/Certificate#:
Specialty/Occupation of Medical Assessor:		Telephone Number:
Mailing Address:		Fax Number:
City/Town:	Province:	Postal Code:
Signature (in ink):		Date:
		STAMP

[2] **Note to Applicant:** A short case history with your doctor may require additional medical documentation from your current and/or previous doctor.